

**STATEMENT OF**  
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**BEFORE THE**  
**COMMITTEE ON VETERANS' AFFAIRS**  
  
**U.S. SENATE**  
  
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Good Morning Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) programs that provide veterans benefits and services.

**S. 1537      Parkinson's Disease Research Education and Clinical Centers;  
Multiple Sclerosis Research Education and Clinical Centers**

Mr. Chairman, I will begin by addressing S. 1537. This bill would require VA to establish six Parkinson's Disease Research, Education, and Clinical Centers (PADRECCs) and two Multiple Sclerosis Centers of Excellence (MS Centers). The bill prescribes detailed requirements for the centers. It would provide that any such center in existence on January 1, 2005, must be designated as a PADRECC or MS Center under this law unless the Secretary determines that it does not meet the bill's requirements, has otherwise not demonstrated effectiveness in carrying out the purposes of a PADRECC or MS Center, or has not demonstrated the potential to carry out those purposes effectively in the reasonably foreseeable future. The centers would also need to

be geographically distributed. Finally, the Secretary could designate a facility as a new PADRECC or MS Center only if a peer review panel finds that the facility meets the requirements of the law, and recommends designation.

VA does not support S. 1537 because it is unnecessary; the Department is already in full compliance with the substantive requirements of this bill. VA recommends that Congress await an ongoing evaluation of the existing PADRECCs before it considers whether to mandate that VA either continue their operation or designate new centers. Additionally, VA is concerned that statutory mandates for these “disease specific” centers has the potential to fragment care in what is otherwise a well-designed, world class integrated health care system. I am increasingly concerned about the proliferation of this disease specific model and its impact on patient care and VA’s integrated health care model. As it relates to a particular disease, I believe that it is much more important for VA to disseminate the best in evidence based practices across its health care system than to establish centers that provide care for a particular disease.

VA currently has PADRECCs at six sites-- San Francisco, California; Richmond, Virginia; Philadelphia, Pennsylvania; Houston, Texas; Los Angeles, California, and Puget Sound/Portland, Oregon (a combined site). Those sites served a total of 18,500 patients in fiscal year 2004. [We are currently conducting an evaluation of](#) PADRECCs’ effectiveness in disseminating best practices, impact on patient outcomes, and the types of organizational structures that contribute to effectiveness. The study will be completed in 2007. Until this study is complete, VA believes that it would be unwise to mandate continued operation of these or additional PADRECCs . VA will, of course, share the results of the evaluation with Congress to assist in determining the need for legislation in the future.

For similar reasons, VA also does not support establishing new specialty centers for the care of veterans with multiple sclerosis. VA is well aware that Parkinson’s disease and multiple sclerosis are prevalent in the veteran

population, particularly among aging veterans. However, the nature of battlefield injuries is changing, and VA is now treating many new veteran patients with complex polytrauma syndromes, including brain injuries, limb loss, and sensory loss. Treating such disorders, and the mental and emotional disorders that accompany them, requires an interdisciplinary approach that moves beyond the focus on a single disease. By mandating new “education, research, and clinical centers” that are disease-specific, flexibility to respond to changing combinations of related conditions is reduced. It is also important to note that the “models” on which PADRECCs and MS Centers are based, the successful Geriatric Research, Education and Clinical Center (GRECC) and Mental Illness Research, Education and Clinical Center (MIRECC) programs, were not as narrowly-focused on a disease process but addressed a wide gamut of issues facing a significant portion of the veteran population.

#### **S. 2433      Rural Veterans Care Act of 2006**

Mr. Chairman, S. 2433 is an ambitious measure to improve access to VA health care and other VA benefits by veterans living in rural and remote areas by creating a new Assistant Secretary who would be responsible for formulating, coordinating, and overseeing all VA benefits, policies, and procedures affecting such veterans. This would include overseeing and coordinating personnel and policies of the three Administrations (i.e., Veterans Health Administration (VHA), Veterans Benefits Administration, National Cemetery Administration) to the extent such programs affect veterans living in rural areas.

Section 2 of the bill would establish a new Assistant Secretary for Rural Veterans (AS) to formulate, coordinate, and implement all policies and procedures of the Department that affect veterans living in rural areas. It would require the new Assistant Secretary to oversee, coordinate, promote, and disseminate research into issues affecting veterans living in rural areas, in cooperation with VHA and the centers that would be established under section 6

of the bill, as well as ensure maximum effectiveness and efficiency in the provision of benefits to these veterans in coordination with the Departments of Health and Human Services (HHS), Labor, Agriculture and local government agencies.

In addition, section 2 would require the Assistant Secretary to identify a Rural Veterans Coordinator in each VHA Integrated Service Network (VISN), who would report directly to the Assistant Secretary and coordinate all the functions authorized under section 2 within his respective VISN. It would also require the Assistant Secretary, under the direction of Secretary, to supervise the VA employees who are responsible for implementing these policies and procedures.

Section 3 of the bill would require the Assistant Secretary to carry out demonstration projects to examine alternatives for expanding care in rural areas. In so doing, the Assistant Secretary would have to work with the Department of Health and Human Services to coordinate care that is delivered through the Indian Health Service, Critical Access hospitals, or Community Health Centers. One such program would have to involve expanded use of fee-basis care for veterans living in rural or remote areas. Not later than one year after the date of enactment of this Act, the Assistant Secretary would be further required to re-evaluate VA policy on the use of fee basis care nationwide and to revise established policies to extend health care services to rural and remote rural areas.

Section 4 of the bill would require the Secretary to conduct a three-year pilot program in 3 VISNs to evaluate various means to improve access to care in highly rural or geographically remote areas for all enrolled veterans and those with service-connected disabilities who live in such areas. In carrying out the pilot, the Secretary would be required to provide these veterans with acute or chronic symptom management, non-therapeutic medical services, and any other

medical services jointly determined to be appropriate by the individual veteran's VA primary care physician and the respective VISN Director. The Secretary would also have to allocate 0.9% of the appropriated medical care funds to carry out this section before allocating any other medical funds.

Section 5 would amend VA's authority to provide beneficiary travel benefits to require that covered lodging and subsistence be determined at the same rates that apply to Federal employees. It would also require that VA's mileage allowance be determined in accordance with the rates that apply to Federal employees.

Finally, section 6 of the bill would require the new Assistant Secretary to establish up to five centers of excellence for rural health research, education, and clinical activities. These center(s) would be required to: conduct research on rural health services; allow for use of specific models of furnishing services to this population; provide education and training for health care professionals; and, develop and implement innovative clinical activities and systems of care.

We share the concern that rural veterans have adequate access to VA health care and other VA services; however, we do not agree that the bill would effectively achieve this and, so, oppose S. 2433. First, the Under Secretaries of the three VA Administrations are responsible for formulating and implementing program policy in their respective areas. The proposed Assistant Secretary could have no direct authority over them or their organizations. The proposed role and responsibilities of the Assistant Secretary, as provided for in this legislation, would cause significant confusion and disruption across organizational lines-- both among, and within, the Administrations.

Assuming there were some way to operationalize the responsibilities of the Assistant Secretary, the ability of the Under Secretaries to manage their employees and respective programs efficiently and effectively would be

significantly reduced. The bill would dilute control from the Administrations with respect to specified activities, personnel, and resources. This would increase the potential for fragmented services, waste, and inconsistent, if not unequal, treatment of veterans based solely on their geographic location. For instance, 23% of enrollees live in rural areas based on the Census' definition of a rural area. However, only four percent of enrollees live in a rural area and travel more than 60 minutes to a VA facility. Under the bill, a disproportionate share of health care resources would be directed to this population. The planning and delivery of services to rural veteran-enrollees would be inconsistent and incoherent with respect to the total population of enrolled veterans. The possibility of fragmentation in the delivery of benefits cannot be overstated.

Second, S. 2433 would adversely dilute the ability of the Under Secretary for Health to manage not only the delivery of VA health care to rural veterans but also the delivery of health care to all veterans because of the significant costs associated with enactment of this bill. The proposed demonstration projects would cost \$225 million based on the President's Budget for Fiscal Year 07. The additional beneficiary travel benefits would cost approximately \$550 million (based on current employee-related rates), and that estimate accounts only for the proposed increase in VA's mileage allowance. Providing per diem (lodging and subsistence) at the proposed rates in addition to the mileage allowance would raise the estimate to well over \$1 billion. Moreover, these increases would assist only the limited categories of veterans who are eligible for beneficiary travel benefits. We believe medical care funds are better directed to the delivery of direct health care for all eligible veterans.

We note that the mandate to expand the use of fee-basis care in the proposed demonstration projects may not be possible, because VA's authority to provide fee-basis care (meaning contract care other than care furnished under a sharing or scarce-medical-specialist agreement) is limited by statute. Further, the mandate ignores the economic impact of expanding the use of fee basis

care. The cost of care in fee settings is typically significantly greater than the cost of the same care provided in VA settings. As a result, while fee-basis expansion may make care accessible for some rural veterans, it would disproportionately reduce the resources available for care of all other veterans. Moreover, we do not understand the mandate to provide non-therapeutic medical services as part of the pilot program and would question the wisdom of providing such service from the three medical care appropriations. Finally, the demonstration projects and pilot project could be achieved, to a large extent, within the current VHA structure and existing authority. It does not require an organizational restructuring, which, again, would create significant risk of fragmentation and lack of continuity of care and benefits.

#### **S. 2500      Healing the Invisible Wounds Act of 2006**

Section 2 of S. 2500 would prohibit VA from implementing any modification of the manner in which VA handles ratings for post-traumatic stress disorder (PTSD) claims for purposes of the payment of compensation until six months after the Secretary submits to the Senate and House Committees on Veterans' Affairs a report on such modification. We do not support enactment of this section of the bill for several reasons. First, VA believes that this legislation is unnecessary because VA currently has no plan to change its procedures for handling ratings for PTSD claims. Second, the bill would represent an unwarranted restriction on the Secretary's Congressionally delegated authority to issue regulations governing veterans' benefits matters, which must be based upon statutory authority, and to manage the implementation of statutorily-authorized benefit programs. Finally, VA is already required to report to Congress on its rulemaking. Under 5 U.S.C. § 801, before a rule can take effect, VA must submit to both Houses of Congress a report on the rule.

Section 3 of this bill would require the Secretary of Veterans Affairs, in consultation with the Secretary of Defense, to provide each member of the

National Guard and Reserves who serves on active duty in a combat theater with readjustment counseling services within 14 days of their return from deployment in a combat theater. Such services would have to be provided through VA's Vet Centers. Services would have to include group counseling, a one-hour session of private counseling, and outreach concerning VA readjustment counseling services and mental health services. Section 3 would also require that the National Guard member or reservist be retained on active duty until receipt of the readjustment counseling services required under the section.

VA does not support section 3 of S. 2500. A returning combat-veteran's need for readjustment counseling and related mental health services will be case-specific. Mandating that all such service members receive this counseling and related mental health services is counter-productive and inefficient in the absence of an individual needs assessment being conducted by an appropriate VA professional. It also violates a fundamental liberty of the service member to be able to choose whether to receive such services, thus violating the hallmark bioethical principle of patient autonomy. Further, we object to legislatively mandating the type of counseling to be provided, including the treatment milieu. Not all of these service members would want or benefit from group sessions, for instance. Indeed, such sessions might be contraindicated in particular cases. We strongly believe that only VA's health care and counseling professionals can and should determine who among the cohort of returning combat soldiers needs readjustment counseling and/or other appropriate related care. Finally, as to the proposal that they retain their active duty status until receipt of VA services, we must defer to the Department of Defense (DoD).

**S. 2634      Eliminating Statutory Term Limits of Under Secretary for  
Health and Under Secretary for Benefits**

Mr. Chairman, S. 2634 would eliminate the current statutory four-year term limit that applies to both the Under Secretary for Health and the Under Secretary

for Benefits position, as well as the currently mandated search-commission processes for identifying candidates to recommend to the President for these positions. VA supports S. 2634 as it would provide the Secretary with needed flexibility as well as decrease the time required to fill these vacancies.

**S. 1731        Redesignation of VAMC Muskogee, Oklahoma**

This bill would designate the Department of Veterans Affairs Medical Center in Muskogee, Oklahoma as the “Jack C. Montgomery Department of Veterans Affairs Medical Center.” We defer to Congress in the naming of federal property in honor of individuals.

**S. 2736        Amputation Centers of Excellence**

S. 2736 would require the Secretary to establish not less than five centers that provide enhanced rehabilitation services to veterans with amputations and prosthetic devices. Each such center would provide special expertise in prosthetics, rehabilitation with the use of prosthetics, treatment, and coordination of care for veterans with any amputation. They would also be responsible for providing information and supportive services to all other Department facilities concerning the care and treatment of these veterans. Each center would have to meet specific staffing and resource requirements set out in the bill. Finally, these centers would not be able to duplicate the services currently being provided by the Department's polytrauma centers.

The Department does not support S. 2736 because it is unnecessary in light of the recent and notable progress VA has made to address the needs of patients with amputations and more complex injuries. VA recognizes the Committee's concern regarding this important issue, not only as it relates to veterans already in the healthcare system but also as it relates to returning OIF/OEF combat veterans. We would like to work with the Committee members

to make sure their concerns are addressed and plans to keep the committee apprised of the progress we make as we continue to integrate the amputation system of care with the polytrauma system of care. VA first developed the amputation system of care in 2004, but as the war progressed and VA saw the dramatic increase in patients with complex, multiple injuries as a result of Improvised Explosive Devices (IEDs), VA developed a comprehensive, integrated system of care to provide rehabilitation to these patients with severe and lasting injuries. Teams at these sites are being trained to provide rehabilitation services across the full continuum of impairments commonly associated with combat injury including prosthetics and amputation. Given our recent decision to open up the additional 17 Level II Polytrauma Network Sites, we believe this legislation is unnecessary, but would be pleased to continue the discussions with the Committee on this important subject.

I would now like to address some of the specific clinical, educational, and research initiatives that are currently underway that obviate the need for this legislation.

### Clinical Care

VA has a long-standing history of providing amputation care, which involves interdisciplinary amputation clinic teams, prosthetic and orthotic laboratories, and Preservation-Amputation Care and Treatment Programs (PACT). We are enhancing our delivery of amputation care to address the needs of returning combat injured veterans who have suffered amputations. These veterans are younger, were previously active and healthy, and have high expectations and goals for life after amputation. Such enhancements include: addition of staff; advanced specialized training for staff; use of advanced prosthetic devices, equipment, and techniques in the rehabilitation process; and, long-range case management services to provide care coordination.

These enhancements are being developed as a complement to, and in coordination with, the polytrauma system of care—not as duplicative efforts. This coordination is necessary because many of the returning amputee-veterans have additional injuries, such as traumatic brain injury, PTSD, or hearing loss, requiring expanded rehabilitation services. The polytrauma system of care is designed to provide life-long rehabilitation services across the full continuum of care. Four Polytrauma Rehabilitation Centers (PRC) and 17 Polytrauma Network Sites (PNS) have been established. The PRCs are located in- Tampa, Florida; Richmond, Virginia; Minneapolis, Minnesota; and, Palo Alto, California. These Centers provide acute inpatient rehabilitation services to veterans with multiple impairments, including amputation. The interdisciplinary teams at the Centers include: physicians; physical therapists; occupational therapists; prosthetists; social workers; case managers; nurses; psychologists; speech therapists; and, recreation therapists.

The 21 Polytrauma Centers (4 PRCs and 17 Network Sites), one in each VISN, address long-range care needs and case management. PNS sites were identified based on specific amputation, rehabilitation, and mental health expertise including:

1. Comprehensive Physical Medicine and Rehabilitation Service
2. Inpatient Rehabilitation Unit accredited by the Rehabilitation Commission (CARF)
3. Prosthetic/Orthotic Lab accredited by ABC or BOC; certified prosthetist on staff
4. Surgical expertise in the area of amputation care and polytrauma
5. Specialized PTSD programming
6. Presence of Driver's Training Program
7. Access to telerehabilitation technology

These sites provide access to specialized services either directly, or via consultation, within a reasonable geographic distance of veterans' home. This interdisciplinary approach is used throughout the continuum of care not just in the patient's acute rehabilitation setting.

As service members progress from the acute care setting to their home environment, their needs for services will change. To meet these demands, our clinical teams must be well versed in evaluation techniques, rehabilitation methods and prescription of equipment.

To that end, VA is working closely with Walter Reed Army Medical Center and Brooke Army Medical Center (BAMC) to provide advanced training in amputation care to VA clinicians. For example, VA has entered into a Memorandum of Agreement with BAMC to provide advanced rehabilitation for patients with amputations at BAMC's newly designed Center for the Intrepid (CFI). The agreement provides for VA staff to be based at the CFI. This staff will have access to state-of-the-art equipment and techniques for amputation rehabilitation. Their duties will include providing regular training sessions to other VA employees. Veterans and military service members will have access to this specialized center for high level rehabilitation.

### Education and Training

Specialized training for prosthetists and therapists in the Polytrauma System of Care has been provided in a number of venues. VA clinicians have received advanced skills training through Walter Reed Army Medical Center and BAMC. At present, VA has 12 teams of prosthetists and physical therapist scheduled to attend the Military Amputation Advanced Skills Training, on May 10-12, 2006. (Teams attended similar training at WRAMC one year ago.) Finally, a joint DoD-VA Amputation Clinical Practice Guideline is being developed to provide guidance to the field in the area of amputation rehabilitation.

## Research

VA has three research Centers of Excellence related to amputation. These Centers address state-of-the-art discoveries in prosthetic equipment, biohybrid limbs, microelectronics and nanotechnology. By collaborating with Rehabilitation Research and Development, the Centers and PNSs will be on the cutting edge of new technology in amputation care. The three Centers are identified below.

- Seattle

- Limb Loss Prevention and Prosthetic Engineering

- Providence

- Tissue Engineering to Rebuild, Regenerate and Restore Function after Limb Loss

- Cleveland

- Advanced Platform Technology

Elsewhere, the Miami VAMC has established a Research Center for Amputation Rehabilitation. Professionals at Miami are actively involved in the development of advanced rehabilitation strategies in amputation care and provide excellent outreach and education to the larger VA community. In addition, the Salt Lake VAMC and the University of Utah have recently been given grants to evaluate strategies related to osseointegrated implants.

## **Other bills**

Mr. Chairman, we do not yet have cleared views on S. 2753 or on Senator Akaka's draft bill on state Homes. Nor do we have cost estimates for these and most of the bills we have discussed. Once we do, we will supply those for the record.

This concludes my prepared statement. I would be pleased to answer any questions you or any of the members of the Committee may have.